Anesthesia Questionnaire and Consent to Treatment

HAVE YOU HAD OR CURRENTLY HAVE:

	YES	NO		YES	NO
Problems with Anesthesia			Tuberculosis		
High Fevers after Anesthesia			Bronchitis, Asthma, Emphysema		
Loose Teeth/ Dentures			Shortness of Breath		
Glasses/ Contact Lenses			Oxygen Dependent. If yes: day & night night only		
Aneurysms			Hiatal Hernia/ Nausea/ Heartburn		
Seizures			Diabetes		
Black Outs (syncope)			Thyroid Trouble		
High Blood Pressure (even if controlled)			Blood Clotting Problems		
Heart Problems:			History of Bleeding/ Anemia		
Heart Attack			Sickle Cell Disease		
Chest pain			Any Neck or Back Problems		
Irregular Heartbeat/ Palpitations			Are you Pregnant now		
Heart Failure			Kidney Trouble		
Heart Surgery			Are you on Dialysis		
Heart Valve Problems			Autoimmune Disease: Lupus or Rheumatoid Arthritis or other: ____		
Heart Stents? If yes, Date:			History of Alcohol or Drug Abuse		
Do you have a Pacemaker			History of Anxiety or Depression		
Pacemaker with Defibrillator Brand: _____			Do you drink Alcohol? (if yes how much?) ____day ____week _____month		
Cardiac Cath in the last 18 months			Any Problems with Sleep Apnea		
Echocardiogram in the last 18 months			Do you smoke/ ever smoked		
Stress Test in the last 18 months			Height: Weight:		

Drug/ Latex/ Tape Allergies: _____

Current medications:

_____

Prior Surgeries: _____

Pharmacy: _____ **Primary Care Provider** _____

Email: _____ : _____ **Race and Ethnicity:** _____

Emergency Contact: _____ **Phone** _____ **Relationship:** _____

Current Insurance: Primary: _____ **Secondary:** _____

I certify that the information above is true and accurate, that I have coverage with the above insurance(s) and assign directly to Gastroenterology & Nutrition of Central Florida (GNCF) all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the disclosure of my health care information in order to obtain payment of insurance benefit information from the above named insurance company (-ies). I also consent to be billed for audio and/or video virtual visits according to Medicare guidelines.

I hereby authorize and consent for medical treatment provided by Gastroenterology & Nutrition of Central Florida. I understand that the physical examination may include a medically appropriate examination of my pelvic area, and/or rectum and I consent to such examination.

Patient Name _____ **Signature:** _____

Last 4 digits of your social security: _____ **Date:** _____